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ABSTRACT

In an increasingly cost-conscious health care environment, average length of hospital stay has decreased. Although psychiatric inpatient treatment is largely exempt from the constraints of the Medicare diagnosis related groups (DRG's), length of stay for geropsychiatric hospital services has decreased also. A trend toward higher rates of early readmission and a greater probability of a more restrictive setting has been observed. Community mental health centers have apparently been overwhelmed by the needs of earlier discharged elderly persons. An intermediary program to carry the patient from hospital discharge to ongoing aftercare through a firm establishment of an outpatient therapeutic relationship at a psychiatric aftercare facility was undertaken utilizing nurse therapy. The goal of this intervention was to aid the former psychiatric inpatient in his transition to an outpatient psychiatric system. It was not intended to replace outpatient therapy, but to formalize a link between the helping networks. A preliminary evaluation has shown that the nursing intensive care model may have been a factor in the return to previous rates of recidivism and disposition. Although data demonstrating the impact of nursing interim care apart from other factors is needed, this nurse therapy model does provide continuity of care from hospital ward therapy through the clinic. (ABL)

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A Model of Nursing Interim Care

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In an increasingly cost-conscious health care environment, average length of hospital stay has dramatically decreased over the past four years (1,2). As acute inpatient care is one of the most expensive aspect of the various modes of service delivery, this development has contributed to a slowing of the spiraling health care expenditures in the United States.

Psychiatric inpatient treatment is not subject to the same reimbursement policies of the Health Care Finance Administration as other specialties. It is, for instance, largely exempt from the implementation of Medicare DRGs (diagnosis-related groups). Nevertheless, decreased average length of stay has been described for geropsychiatric hospital services as well (3). Besides, we observed an associated trend toward higher rates of early readmission and greater probability of disposition to a setting more restrictive than prior to admission (3).

Although the exploratory, descriptive data presented, permit no conclusions as to causality, a mismatch between the needs of earlier discharged elderly patients and availability of adequate community resources was suggested. The suspected discrepancy motivated further investigation of the situation. The specific focus was directed at the smoothness of the transition of elderly inpatients leaving the psychiatric inpatient setting for a community mental health center (CMHC), charged with the provision of aftercare services on an outpatient basis. It appeared that outpatient facilities in the community were overwhelmed with the demands for their services. Clinics began to institute waiting-lists for discharged hospital patients resulting in delays from two weeks to two months between hospital discharge and intake at the CMHC.

Problems are compounded in those clinics that do not have specific geriatric outreach programs. Patients who are given an intake appointment several weeks after their discharge date, frequently fail to show up for the appointment. Some of them may, in the mean time, decompensate and return to the hospital. Forty percent of the clinics in the Greater Cincinnati Area provide geriatric outreach programs. Case-workers in these facilities are in a position to arrange for a home-visit when their patient fails to keep the initial appointment. Clinics without such a service simply strike a "no-show" from their files.

The observations reported (3) demonstrated correlations. They did not provide hard evidence that "falling throughout the cracks" between hospital and outpatient aftercare is a sole cause for higher rates of early recidivism, or that inadequacy of readily available geropsychiatric ambulatory care leads to unnecessarily restrictive placements of discharged inpatients.

The associative relationships, however, seemed compelling enough to stimulate development of an intermediary, bridging program. It was proposed to implement a supportive net that would carry the patient from his or her discharge from the ward through firm establishment of an outpatient therapeutic relationship at the facility charged with ongoing psychiatric aftercare. Additional support for this proposal was gained from a 1983 study by Sadavoy and Reiman-Sheldon (4) which showed that it is crucial follow-up be implemented soon after discharge lest the patient lose contact and reject the recommended treatment plan.

The Model

Nurse therapy has been demonstrated to be an effective intervention for patients classified as neurotic, and receiving psychotherapeutic treatment in a primary care setting (5). In the case of patients in an acute care psychiatric inpatient ward, the period of intensive in-hospital therapy serves to establish a sound therapeutic bond between patient and primary nurse. It appears logical to build the design of the intermediary intervention on this established relationship. It was decided that patients discharged from the geropsychiatry service of the hospital would be seen on an individual basis between discharge and initiation of clinic therapy in the community. Underlying such a temporary transitional follow-up would be a contractual agreement between primary nurse and patient to meet at a mutually agreed upon frequency (but not more frequently than once per week) until the patient was established at a community mental health center. The need for the service would be determined on a case-by-case basis with input from the entire interdisciplinary treatment team.

The program is concisely outlined in the following statutory paragraphs (6), underlying the establishment of Nursing Interim Care as a novel transitional intervention.

Purpose: The goal of Nursing Interim Care is to aid the former psychiatric inpatient in his/her transition to an outpatient psychiatric system. This service is offered when there is a lapse of time between available outpatient therapy and a patient's discharge date. It is not intended to replace outpatient therapy, but to formalize a link in the professional helping networks. This is a contractual relationship between the patient and his or her

Primary Nurse. This continuity of care will allow the nurse an opportunity to assess the patient's medication compliance, interactions with significant others and overall reintegration into the community. Hopefully, this service will decrease the number of repeat admissions by bridging the transition through a caring biopsychosocial support system.

Scheduling: The Treatment Team in the hospital will determine the need for interim care beginning at discharge of any patient from an acute psychiatric inpatient setting. The Primary Nurse will give the patient an appointment time. An appointment book will be centrally located and patients will be given a card indicating the time of the next visit. Office space will be provided for these sessions.

Billing: The nurse will fill out a billing form which is stamped with the patient's clinic card. The time spent by the nurse on these visits will be logged on the exception report to help account for staff nurses' time off the inpatient unit in pursuit of nursing interim care duties.. The billing form will be turned over to the hospital for processing and eventual conveyance to the patient or third party payer.

Time Boundaries: The total time of these sessions will be forty-five minutes (thirty minutes for counseling and fifteen minutes for documentation). Normally there will be one to six visits, but additional visits may be contracted if necessary. Hours will be flexible to include weekend and evening hours. If the patient is legally incompetent, the court-appointed guardian will be asked to give consent for this service.

Supervision: A faculty psychiatrist will provide medical-psychiatric supervision. Advanced degreed registered nurses will provide clinical supervision of the supportive psychotherapy.

Preliminary Evaluation

The decreased average length of duration of hospital stay for geropsychiatric patients was found to influence rates of recidivism and more restrictive disposition only temporarily. Our later data indicated a return to near the old rate, at a time when in-hospital stay was twenty percent longer on the average (7). In other words, the drastic reduction of length of stay first caused early readmission rates to rise and disposition to tend toward greater restrictiveness, but within two years, these trends reversed. In our original analysis (7), we suggested that more effective therapeutic utilization of the shortened period of in-hospital stay was a factor responsible for the phenomena observed. The reversal of the trend occurred over the same period that the nursing interim care model was introduced. We propose that the implementation of this model may have been an additional contributing variable ensuring more satisfactory treatment outcome.

The concept of Nursing Interim Care further builds upon the known fact that symptom remission alone is no guarantor of sustained mental health and autonomous functioning. Re-establishment of a patient's sense of self-worth is an essential ingredient of successful adjustment to life outside the institution (8). The psychological work needed to attain improved self-esteem can at best be initiated within the brief period of time a patient remains in an acute psychiatric inpatient environment. The outpatient aftercare, preferably coordinated through a case-manager, is the setting where such work must take

place. Continuity of care from the hospital ward where therapy started through the clinic is needed to ensure patients' compliance and to enhance their chance at successful negotiation of the adjustment process. The constancy of site and therapist offered by the Nursing Interim Care model seems to meet the needs.

Conclusion

Decreased length of stay of geropsychiatric hospital patients, increased recidivism and a trend toward more restrictive disposition, combined with growing waiting-lists at community mental health centers, suggested the institution of a transitional supportive treatment modality. A hospital-based Nursing Interim Care Model was instituted. The therapeutic alliance between patient and primary nurse is utilized as a vehicle to help the patient negotiate the crucial phase of transition from hospital ward to outpatient clinic. Subsequently collected data are consistent with a positive rehabilitative effect of the model. However, in order to rigorously evaluate the effectiveness of the service, pertinent data will have to be generated to compare the impact of Nursing Interim Care with a control group without transitional support. Ultimately, it will be incumbent upon the clinicians to demonstrate the cost-effectiveness of the model as a preventive intervention in the care for severely mentally ill elders in the community.

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